MHNIG NEWSLETTER

Summer/Fall 2006

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UPFRONT Report from the President

Welcome to the Fall 2006 MHNIG Newsletter! I trust that everyone enjoyed a wonderful summer and good luck as you transition to autumn activities. Congratulations to all MHNIG members who are newly Certified in Psychiatric and Mental Health Nursing Canada - CPMHN(C). Also, we look forward to seeing you at the MHNIG Annual General Meeting (AGM) at Oakville Trafalgar Memorial General Hospital site in Oakville, ON on Saturday, October 28th, 2006. Registration details and AGM Agenda are provided on page 5. Thank you to Pat Nashef, President Elect and Newsletter Coordinator, for leading the AGM Planning Committee and hosting the 2006 MHNIG AGM at her health care organization. Pat has been working tirelessly to plan the autumn 2006 MHNIG AGM and coordinate this newsletter edition.

Under the leadership of Steven Holbert, Communications Officer, MHNIG secured a web designer to launch our new website. Thank you Steven for inputting the web content and providing support to the Executive and Satellite Representatives to advance our web design skills. All MHNIG members can access the website by **USER ID: member2006** and **PASSWORD: mhnig**. The website includes minutes from MHNIG meetings, political action or policy letters, MHNIG activities, the MHNIG By-laws, past newsletters, Members' Voices, and lots of other relevant information. If you have information that you would like to share with the MHNIG membership, please send it to inquiries@mhnig.org and it will be posted.

Notably, we had considered mailing the revised 2006 MHNIG By-laws in paper version to each MHNIG member but because it is such a large document; the photocopying charges, stuffing and mailing costs would be significant. Therefore, the 2006 MHNIG By-laws can be reviewed from the MHNIG website. We are encouraging each of you to review the 2006 revised MHNIG By-laws before the October 28th MHNIG AGM as we will be voting on the revisions. If you require a paper copy, please send an e-mail with mailing address to inquiries@mhnig.org by September 30, 2006 and a paper version will be mailed directly to you. Thank you to Tricia Stiles, Past President for leading the review and MHNIG By-laws revisions.

On page 7, Naomi Mudachi, Socio-Political Action Officer provides a summary of her activities and gratefully, Naomi represented MHNIG at RNAO Head Office in the preparation of the RNAO formal response to the Health Professions Regulatory Advisory Committee (HPRAC) recommendations on the regulation of psychotherapy. Also, Naomi developed the MHNIG response which was forwarded in July and subsequently, the HPRAC confirmed it reception and we await the final outcome.

Notably, three students or recent nursing graduates have contributed significantly to this edition. We start with Lauren Baker's experience of her psychiatric rotation on page 2. Then on page 3, Marianne Rigatti, Student Representative, shares her phenomenological understanding of *recovery* through the eyes of a consumer-survivor-advocate, Chris Whittaker. Also, Marianne has been instrumental in recruiting Chris to participate on the panel at the MHNIG AGM. Thank you to both Marianne and Chris for their dedication and advocacy to the recovery movement. Finally, Archna Patel, past Student Representative and newly appointed Co-Officer, Membership and Education, shares her insights regarding trauma, resilience and revictimization on page 8. Undoubtedly, these three submissions demonstrate the strength and insights of the next generation and future of mental health nursing.

(Continued on page 2)

Student Corner

Journal 3- Psychiatry Rotation *By Lauren Baker*

A meaningful event that happened during my third week of the rotation occurred during a group session that I sat in on as a student observer. The patients were talking about what brought them into the hospital. I was intrigued because it was a chance to get an inside scoop on mental illnesses. However, this inside scoop was eye opening and frightening at the same time.

A lot of the patient's had something in common; stress and a drive for perfection. Now what they experienced was an extreme, but what is to say that I will never drive myself that far into something. It made me have a reality check and realize that although it is good to be goal oriented and have things that drive you in your life, it's not healthy to let them overpower you and your life. One of the patients was talking about his job and how he just wanted it to be perfect to the point that he couldn't stop. He had no shut off button. So he worked and worked, he didn't sleep for six days, and that's when the psychosis began and here he is.

In watching a video in our community nursing class, the lecture was centered on homelessness. In the video a homeless man told his story and said, "You're only a step away from being homeless". He was referring to the fact that he was laid off from his job and now he is homeless. This circumstance is so common in the 20th century. Similarly, I would say, "Were just a step away from landing ourselves on a psychiatry floor." Yes, this is an extreme but in the 20th century we take life to the extreme. We have a need for perfection. We are told that we must have perfection and nothing less. This type of message has only caused anorexia, depression, insomnia, obsessive-compulsive disorders etc., etc.

Listening to the patients talk about their story I reflected on my own. Last semester in school I easily could have been someone sitting in that room as a patient. I had a tremendous need to be perfect and I created unrealistic expectations for myself. I worked at the hospital, I taught dance two night a week, was involved in choreographing a production, danced twice a week, went to nationals, worked out, went to all my classes, worked hard at each and every assignment and still managed to fit my dog in, my friends and my boyfriend. However, what I missed in the whole mix was me. I drove myself way too hard, to the point where I wasn't happy. In the midst of conquering everything that I wanted to do, I lost myself.

I feel that being in the nursing program may have helped me not end up on the other side of the group therapy room, in that I am very aware of myself now and what my limits are. Thus, I was able to know what I needed to do to get myself back on track and set more realistic goals. I cut out some less important goals so that I can enjoy each and every day. This I was able to accomplish and I have to say that it has made a huge difference in my life.

Overall, what I learned about this experience is that it is very important to be aware of how hard I am pushing myself. I now know what my limits are, know how to set more realistic goals and know that I can't do everything. As one of the patients said "I want to be super mom". Well I'd like to say, "Super mom doesn't exists". No one is perfect. The point is to be happy!

(***Continued from page 1)***

Finally, Katie Ungar, Financial Officer breaks down the $15.00 MHNIG membership fee distribution on page 7 through a pie diagram. As Financial Officer for the past decade, Katie has effectively managed our finances and contributed to the financial security of MHNIG. Notably, Katie manages the term deposit, chequing account, membership fees from RNAO Head Office and transfer of funds ($20.00 of $35.00 fee) to the Canadian Federation of Mental Health Nurses. And importantly, she signs all cheques for the newsletter, teleconferences, AGM meetings, website development and much, much more!!! Thank you Katie!

As you can see from my President's Report, I have recognized the fabulous contributions of some of our Executive but unquestionably, each MHNIG member contributes across the domains of nursing in practice, leadership, education, advocacy/policy and research and I feel privileged to represent each of you through our provincial professional association. The April and August Members' Voices provide evidence of your fabulous contributions which can be reviewed on the MHNIG website. Finally, please consider sharing your or your Satellites contributions through the MHNIG website or next newsletter edition. The RNAO Assembly occurs Saturday, September 16th in Toronto, ON and I look forward to representing the MHNIG. And I look forward to meeting many of you at the Saturday, October 28th MHNIG AGM in Oakville, ON. Please attend so that we can surpass our previous attendance numbers and *"hear the story"* and further develop our advocacy skills!

Yours in nursing, **Valerie Grdisa, President**

Empowering Recovery through the Lived Experience

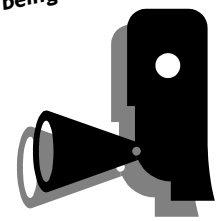
By Marianne Rigatti

The year 1989 was a big year for several reasons, including the fall of the Berlin Wall; the sinking of an oil tanker in Alaska resulting in a massive oil spill; the debut of *The Simpson's* premieres and Chris Whittaker fell ill. During this year, Chris was diagnosed with schizophrenia while attending the University of Toronto. Fast forward to 2006 and Chris is 40 years old and working as a consumer/survivor Information Assistant with the McLaughlin Information Centre at the Centre for Addiction and Mental Health (CAMH). In his other work in the mental health field, Chris provides information regarding mental health to members of the public at various events across the city. However, the information he imparts is driven not by clinically-based sources; instead, he draws on his personal experience with the mental health system. Like Chris, many people living with mental health conditions are offering their stories. This article seeks to uncover the relationship between recovery and empowerment by way of dialoguing the lived experience. First, the impetus for this emerging movement with mental health consumers will be explored. Furthermore, the means in which people express rich, meaningful narratives will be highlighted. Finally, the impact on mental health/psychiatric nursing will be discussed.

Empowering Recovery:

"The goal of the recovery process is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human. The goal is not normalization. The goal is to become the unique, awesome, never to be repeated human being that we are called to be.

The philosopher Martin Heidegger said that to be human means to be a question in search of an answer. Those of us who have been labelled with mental illness are not de facto excused from this most fundamental task of becoming human.



In fact, because many of us have experienced our lives and dreams shattering in the wake of mental illness, one of the most essential challenges that faces us is to ask, who can I become and why should I say yes to life?" (Deegan, 1996)

Recovery is not a linear process. It is met with inevitable peaks and valleys that come to symbolize an indefinite journey. For Chris, recovery came when he transitioned from hospital-based treatment to community care in the statement, "I found the relaxed quality of being treated in the community was just reward for meeting recovery benchmarks while in hospital. Quickly 'graduating' to community care I believe positively affected my further recovery." Empowerment has its roots in the development of the Recovery Movement, which began in the 1970s in the United States (Schiff, 2004). Fueled by the oppression that they faced in state-psychiatric hospitals, ex-patients banded together to raise awareness of the stigma and care they received.

Directed by the principles of empowerment, self-help, and advocacy, the paradigm shift promoting recovery from a mental illness has given more legitimacy to the lived experience of consumers (Schiff, 2004). For Young and Ensing (1999) the process of recovery is divided into three separate phases, of which the last phase is marked by a desire to reach out and help other consumers. A sense of power lost of the nature of the psychiatric problem is restored at this stage for one who chooses to share their story. In an article by Nelson, Lord, & Ochocka, *empowerment* is represented as the individual moving from "a state of powerless to having more power" (2001, p. 126). This is accomplished by community integration in combination with supportive environments and relationships. When asked about his feelings surrounding public speaking, Chris reflects on the setting itself, "Generally, safe situations have been set up for me to relate my experience. When presentations are not as organized or structured...it surprises me but I actually become agitated - not about relating my experience, per se - just that I appreciate a structured, organized environment to present it."

An additional and significant part of empowering conditions includes the response of the community and mental health organizations assisting in various forums for consumer-survivor advocates. Nelson et al. actually outline an "Empowering condition" as deriving from "Responsive organizations and communities" (p. 132). Empowerment is literally a joint effort by individuals experiencing mental and emotional difficulties and those who traditionally have held the power—mental health workers. More recently, changes in services have caused a shift towards more equitable relationships between clinical staff and clients (Nelson et al.). Partnerships between service users and service providers have set the stage for different self-expression opportunities to take place.

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Setting the Stage

With over ten years of experience, Chris Whittaker is definitely not shy in front of audiences. He often is invited to present his story to the community and can be portrayed as empowerment actualized. According to Nelson et al. (2001), an ecological analysis has revealed a three-tiered conceptualization of empowerment. First, at the *micro* level, the social support obtained from peers, friends, family, and helpers enable individuals to share their stories. Empowerment can be reached through the transactional relationships between these supportive influences and the individual by means of communicating thoughts and feelings. The *meso* level strives to enhance empowerment through mental health organizations that make opportunities available for people to participate in the community through self-expression of their lived experience. The *Courage to Come Back Awards* organized by CAMH is an annual event that acknowledges people who have demonstrated resilience despite experiencing distressing mental health problems. Moreover, the Schizophrenia Society of Ontario offers a *meso* level take on empowerment by being an organization dedicated entirely to promoting schizophrenia awareness in multiple ways, including self-help groups. On a different note, the *macro* level involves the broader spectrum of mental health policy-making, which incorporates important elements such as funding for self-help services, employment and housing. A macro level example of consumer participation would be the Psychiatric Patient Advocate Office (PPAO). The PPAO was established in 1983, funded by the Ministry of Health and Long-Term Care to protect the legal rights and entitlements of inpatients in the provincial psychiatric hospitals. These examples are just a snippet of the ways in which consumers are enabled to share their personal accounts of being affected by a mental health condition. It has been suggested by consumers that social participation wherein their skills are used effectively are significant to the recovery process (Schiff, 2004).

New Frontier

The last stage of the recovery journey which Young and Ensing (1999) describe involves both the consumer's desire to reach what they deem to be their optimal level of functioning and their desire to help other consumers. A sign of this will be evident at the next **MHNIG Annual General Meeting** taking place on **Saturday October 28th** at **Oakville Trafalgar Memorial Hospital**. The event will focus on *Hearing the story; a journey of living and mental illness.* Attendants will have the opportunity to listen to the full story of Chris Whittaker. Also, Helen Kirkpatrick, PhD—the Coordinator of the Mental Health Nursing Specialty and a Nursing Professor at the McMaster Nursing graduate program—will present her work on the "Theory and practice of the Value of Telling and Hearing the Story." A panel discussion focusing on how we can further the advocacy for persons living with mental illness will close the day. All RNAO members are encouraged to attend as an opportunity to meet fellow colleagues who are also inspired to work in the scope of mental health and psychiatry.

References

Deegan, P. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, *19*, 91–97.
Schiff, A. C. (2004). Recovery and mental illness: analysis and personal reflections. *Psychiatric Rehabilitation Journal, 27*, 212-218.
Young, S. L., & Ensing, D. S. (1999). Exploring recovery from the perspective of people with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 22*, 220-231.

By-Laws—Revisions to be reviewed at October 28th MHNIG AGM

Please take the time to review the draft revisions of our MHNIG By-laws. They are posted on the MHNIG web site at www.mhnig.org. You can log into the website by **USER ID: member2006** and **PASSWORD: mhnig**. In August 2006, a broadcast e-mail was sent to all MHNIG members with the revised 2006 MHNIG By-laws. If you require a paper copy or you did not receive this e-mail, please send an e-mail with mailing address or e-mail address to inquiries@mhnig.org by September 30, 2006 and a paper or electronic version will be mailed directly to you. We look forward to your attendance at the AGM on October 28th at Oakville Trafalgar Memorial Hospital Site in Oakville, ON when the by-laws will be tabled. If you are unable to attend and have feedback regarding the By-laws, please forward them to inquiries@mhnig.org or inform you Satellite Representative at provided contact information on Last Page. See you in October !!!

The Mental Health Nursing Interest Group of Ontario Conference and Annual General Meeting

Saturday, October 28, 2006
Halton Healthcare,
Oakville Trafalgar Memorial General Hospital site
Oakville, Ontario

Don't miss this exciting opportunity to meet with Mental Health Nurses from across Ontario to share experiences and network, while contributing to the ideas that will shape the directions of the Mental Health Nursing Interest Group of Ontario.

Who should attend: *Registered Nurses working in the area of Mental Health/Psychiatry, Registered Nurses working in other areas who are interested in Mental Health, nursing educators and nursing students.*

Fees: MHNIG Members & Non-Members – **No Charge**
All are Welcome

	Morning Session		**Afternoon Session**
0830 – 0900	Registration	1300 – 1400	Hearing the story; a journey of living and mental illness
0900 – 0915	Opening Remarks	1400 -1445	Theory and practice of the Value of Telling and Hearing the Story – Helen Kirkpatrick, PhD, McMaster University School of Nursing
0915 – 1030	Business Meeting	1445 – 1500	Break
1030 – 1045	Break	1500 - 1545	Panel discussion on how we can further the advocacy for persons living with mental illness
1045 – 1200	Business Meeting	1545 – 1600	Closing Remarks
1200 – 1300	Lunch provided		

Hosted by: Halton Healthcare Mental Health Program

Seating is limited - pre-registration is a must to ensure adequate catering.
RSVP deadline is Friday, September 29, 2006.

Please Print: **MHNIG Member [ ]** **Non-Member: [ ]**

Name: _____ **Title:**_____

Organization:_____ **E-mail:**_____

For further information or to **RSVP:**

Pat Nashef, Mental Health Program

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Awards & Scholarships

Congratulations to the 2006 Recipients!!!

Jasmine Williams Memorial Award

Awarded to a Ryerson University nursing student from the Collaborative or Post RN program, demonstrating a genuine interest in the well-being of the mentally ill client, academic proficiency and nursing practice excellence.

2006 Award Recipient: Mridula Sury

On June 1st, 2006, Archna Patel represented MHNIG at the Ryerson University Awards Ceremony which recognized Mridula Sury as the 2006 Jasmine Williams Memorial Award recipient. Archna shares, "it was wonderful to hear about Mridula's passion towards clients with mental health conditions and her ambition to help vulnerable populations." Mridula's summarizes her passion towards mental health nursing and clearly exemplifies her insights including career goals:

"As a nursing student with aspirations leading up to the doors of The World Health Organization, I feel the need for more community involvement with regards to mental health care for our vulnerable populations. I know that my long term commitment to this will see me through my desire to work on an international scale. I hope as well, one day, to work with a team of professionals, bringing health care to those in dire need in developing nations, such as *Doctors without Borders.*"

Dr. Hildegarde E. Peplau Award

Awarded to a Registered Nurse who wishes to pursue education at the master's or doctoral level in psychiatric-mental health nursing. Preference will be given to those whose focus of study includes an interpersonal perspective in nurse-client, family, peer or community relationships. Preference will be given to MHNIG members. Visit www.rnfoo.org for 2007 deadline and application process.

2006 Award Recipient: Angelique Benois

Angelique was recognized at the 2006 RNFOO Gala in Toronto but she was unable to attend. She is enrolled in the School of Nursing, Master of Science/Nurse Practitioner Program at Stony Brook University in New York. Currently, she works at Sick Kids in Toronto on the Psychiatry Assessment and Treatment Unit and Eating Disorders Program. Her goal is to work as an Acute Care Nurse Practitioner to provide outreach mental health care to children in underserviced and vulnerable communities.

Angelique is predicted "to make a valuable contribution to child and adolescent mental health nursing." She has earned public recognition and the respect of colleagues as evidenced by the nomination for the Toronto Star's Nightingale Award.

NURSING PRACTICE COMMITTEE — MHNIG REP NEEDED!

MEMBERSHIP

The Interest Group representation is rotated every two years and for the 2006-2008 term, it's MHNIG's turn! We are looking for a volunteer to join the Nursing Practice Committee. Please submit your contact information with a brief message by e-mail to inquiries@mhnig.org by Monday, September 25, 2006 if you are interested in representing MHNIG.

COMMITTEE PURPOSE: The Nursing Practice Committee assists in strengthening the position of the registered nurse within the context of the health care system in Ontario by: (1) serving as a linkage at a professional level for RNAO affiliate interest groups which have a practice focus; 2) identifying common nursing practice issues among the above interest groups and the membership at large; (3) developing a strategic plan for recommendation to the Board of Directors with respect to common nursing practice issues in keeping with the Mission and Ends of RNAO; and (4) serving as a linkage with other nursing professional groups (ONA, CNO).

COMMITTEE RESPONSIBILITIES:

- Identify as well as address emerging practice issues among Interest Groups and membership at large
- Serve as a resource and advisor to the Board of Directors to address common issues/concerns of registered nurses working in practice settings across the province.
- Provide materials that strengthen the role of registered nurses in the practice setting.
- Collaborate with the Member of the Policy and Development and Analysis Committee in lobbying the Ministry of Health in relationship to the role of the RN.
- Promote the professional image of the registered nurse within and outside the Association.
- Collaborate with RNAO Member Groups. (i.e. Member Education, Member Research Clusters and Provincial Nurse Administrators Interest Group)
- Conduct 6 month review of positive/negative practice issues across the province (Use Members Voices as a scan)

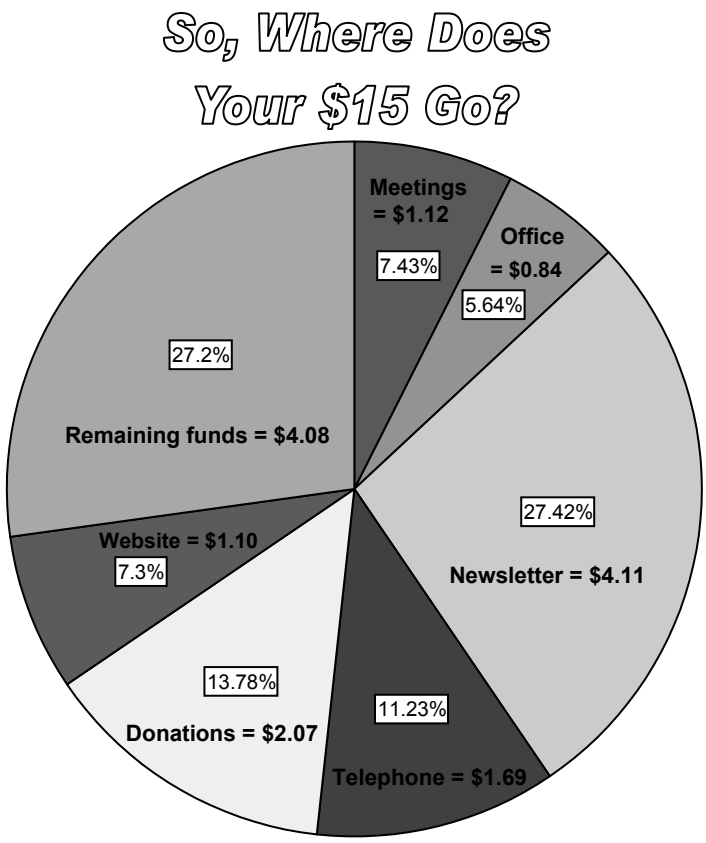
We look forward to e-mails from all interested MHNIG members and a decision with communication will occur by October 1, 2006.

Financial Corner

Katie Ungar, Financial Officer

Greeting MHNIG members! As you are aware, $20 of the $35 RNAO fee is transferred to CFMHN. This pie chart demonstrates how your **$15** MHNIG membership fee was spent in this fiscal year (2005/06) Notably, the newsletter rate ($4.11) does not account for this newsletter edition and therefore, the *remaining funds* will cover this edition. Remember, each MHNIG member can access $5.00 per-member/satellite to fund satellite meetings, educational events and various expenses. We also have a chequing account and term deposit which contribute to our financial viability.

Chequing account balance**:** $13111.18
Term Deposit plus interest: $12882.37



Financial Report As of July 12,2006

Revenue:	Membership	$24447.50
	Interest(bank)	1.81
	Donations(inserts)	470.00
	Total:	24919.31
CFMHN- Membership (699 x $20)		- 13980.00
Total MHNIG Revenue:		**$10939.31**
Total Expenses: (see pie chart for distribution)		- $7963.74
Balance from 2005/06 Revenue:		**$2975.57**

Sociopolitical Corner

Naomi Mudachi, Socio-Political Action Officer

Firstly, I wanted to thank all those members who submitted areas for potential political action. All the suggestions submitted were very thoughtful and important areas for action. In the past few months we have focused on addressing two issues; the regulation of psychotherapy and mental health under the Local Health Integrations Networks (LHINs).

In regards to the regulation of psychotherapy, the recommendations of the Health Professions Regulatory Advisory Committee's (HPRAC) were released which recommended the regulation of psychotherapy. Go to link: http://www.health.gov.on.ca/english/public/program/pro/hprac.html Also, the link may be accessed on the MHNIG website. MHNIG and RNAO provided a response; primarily responding to the definition for the scope of practice provided and educational requirements. Our responses suggested including a preventative and health promotion focus in their defined scope of practice for psychotherapy as well as requesting that the educational requirements for mental health practice be distinguished from psychotherapy.

In regards to the LHINs, some important areas for advocacy have been to ensure that mental health has been on the agenda for all the LHINs as well as sustaining a viable mental health system (very broadly defined) under the LHINs. A great majority of the LHINs have mental health as one of their high level action areas, indicating that mental health is a priority at the LHIN level. We are continuing to explore methods of advocating for mental health at the provincial level. In addition, all the LHINs have been conducting general community meetings, which are a great way to get involved in local communities to advocate for mental health at a regional level!

Young Women Survivors of Childhood Sexual Abuse: A Link Between Resilience and Sexual Revictimization?

By Archna Patel

Background

While working in mental health, I have encountered and witnessed the effects of mental illnesses and how they change and alter a person's life. I have always questioned and wondered what their childhood and development was like, and what stressors might they have had along the way that contributed to their current state.

Nothing stands out more to me to this day than my encounter with a 29 year old female who was the victim of childhood sexual abuse (CSA) at the age of 5. Subsequently, she has been in and out of the psychiatric ward for many years trying to cope with her past and continually being sexually revictimized as an adult by others in the present- she is haunted by her past experiences that offer her no escape in the present.

I was curious as to whether there is a correlation between resiliency and preventing further sexual revictimization during adulthood and if so, what is the link? What can be done to foster resiliency so as to prevent further sexual revictimization in order to stop this cycle? What can we as nurses learn from CSA survivors and how can we facilitate the prevention of sexual revictimization?

Introduction

The long term effects of childhood sexual abuse (CSA) have been well documented. CSA survivors struggle through a myriad of psychosocial issues and often times, destructive and ineffective coping mechanisms throughout their childhood, adolescence and adulthood. Understanding the protective and risk factors for this group may shed some light into why CSA survivors have a chronic, long term sequelae.

Resilience is a well known protective factor studied in children who have lived with many childhood struggles. Although the concept of resiliency in children has been well documented, only recently has it been examined within the context of CSA. Another concept that is only now being more thoroughly investigated is sexual revictimization during young adulthood among CSA survivors. This article will examine what current studies have determined as factors of resilience for female CSA survivors in young adulthood, and if there is a link with sexual revictimization.

Why So Important?

One in three girls and 1 in 6 boys will be sexually abused during their childhood (Arata, 2002; Maker et al., 2001). Therefore there are many adults among us who have experienced CSA. Furthermore, of those female CSA survivors, the rate of sexual revictimization as an adult is 48% to 66% (Arata, 2002; Casey & Nurius, 2005; Maker et al., 2001). Why is this percentage so high? Unfortunately, there is a direct inevitable link between CSA and sexual revictimization in adolescence and adulthood (Arata, 2002; Casey & Nurius, 2005; Maker et al., 2001). Is there anything that can stop this from occurring? Perhaps understanding resilience in CSA survivors and putting into place factors that facilitate resilience will decrease revictimization. Therefore it is important to understand why sexual revictimization occurs and how resilience plays a role in decreasing the chances of sexual revictimization.

The Concept of Resilience

Resilience is defined as the capacity for successful adaptation despite challenging or threatening circumstances (Simpson, 2004). McGloin and Widom (2001) examined resilience in young adult CSA and physical abuse survivors aged 22 to 33 years old who have experienced CSA or physical abuse between the ages of 0- 11 years old. This study assessed these individuals' level of resilience based on eight domains that the researchers believed indicated resilience.

"The Eight Domains":

1. successful employment within the past 5 years
2. no periods of homelessness
3. having at least graduated from high school
4. engaging in social activities with family, friends, and/or other people for the purpose of a hobby a leisure activity, or for a religious purpose
5. not having a diagnosis of the following psychiatric disorders: generalized anxiety disorder, post-traumatic stress disorder (PTSD), antisocial personality disorder, depression and/or dysthymia
6. no substance abuse which includes alcohol abuse, drug abuse and/or a dependence diagnosis
7. not having any criminal arrests excluding simple traffic offences
8. no self report of harming others in any way through physical force, using weapons and sexual assault.

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The study determined that sexual abuse was a negative predictor of resilience whereas physical abuse was not. Achieving 6 out of the 8 domains illustrated resilience. From the group of 338 interviewed females, only 27% met the criteria for resilience.

Another study by Hyman and Williams (2001) interviewed women aged 18 to 31 years old- one question they were asked was whether the participants were revictimized. 12% of the resilient women were sexually revictimized as adults and 35% of the nonresilient women were sexually revictimized as adults. Overall the study's findings concluded that resilient women have six variables that explain their resilience: 1. growing up in a stable family; 2. not experiencing incest (i.e. perpetrator is a family member); 3. not experiencing physical force as a part of the sexual abuse; 4. not being arrested as a juvenile; 5. graduating from highschool; 6. not being sexually revictimized as an adult.

The Concept of Sexual Revictimization

Sexual revictimization has been defined as at least one incident of sexual abuse in both childhood and adulthood (Maker et al., 2001). This definition originated in research documenting that victims of CSA are at a greater risk of experiencing adult sexual assault (Maker et al. 2001). Studies examining the predictors of sexual revictimization have found that experiencing CSA is a direct risk factor and predictor for sexual revictimization in young adulthood (Arata, 2000; Casey & Nurius, 2005; Maker et al. 2001; Messman-Moore et al., 2005). Arata (2000) concludes that female CSA survivors are 1.5 to 2.5 times more likely to be sexually revictimized in adolescence and adulthood than their nonvictimized peers. Studies indicate that having PTSD growing up in unstable environments with abuse, violence and neglect and a negative non-supportive reaction towards the children reporting the CSA from a parent or caregiver places CSA survivors at a higher risk of experiencing sexual revictimization (Arata, 2000; Casey & Nurius, 2005; Maker et al. 2001; Messman-Moore, et al., 2005). The long term effects of these childhood experiences are drug and alcohol abuse, PTSD, self blame and poor ratings of personal health (Arata, 2000; Casey & Nurius, 2005; Maker et al. 2001; Messman-Moore, et al., 2005).

The Link Between Resilience and Sexual Revictimization

McGloin and Widom (2001) stated that having not been diagnosed with substance abuse and PTSD were indicators of resilient women. At the same time Arata, 2000; Casey & Nurius, 2005; Maker et al. 2001; Messman-Moore, et al., 2005 indicated that PTSD is a direct predictor of sexual revictimization and that substance abuse can be deduced as a predictor. Secondly, two studies that looked at resilience (Banyard et al., 2002; Hyman & Williams, 2001) indicated that growing up in a stable home resulted in resilience in adulthood; which also places CSA survivors at a lower risk of experiencing sexual revictimization. (Arata, 2000; Casey & Nurius, 2005; Maker et al. 2001; Messman-Moore, et al., 2005). Therefore, we can see the link between resilience and sexual revictimization: resilient women do not experience PTSD from their CSA and do not engage in substance abuse whereas women who have been sexually revictimized would have had PTSD from their CSA and can be substance abusers. Lastly, growing up in a stable home can promote resiliency and hinder factors leading to sexual revictimization. To summarize, in all of these studies only a few findings indicate that resilience may be a protective factor against sexual revictimization. Nevertheless, this still proves that there is an association between resilience as a possible protective factor for sexual revictimization.

Implications for Future Nursing Research

The relationship between resilience and revictimization needs to be further explored to obtain a better understanding. Nursing research needs to delve into closing the gaps discussed here. Since nurses are front line workers, they will encounter sexually abused children, adolescents and adults first. It is therefore important for the profession of nursing to embark in research studies examining these concepts and relationships. From these studies, nurses can gain a broader understanding on the meaning of CSA and resiliency in children, adolescents and adults, how it may be a protective factor against sexual revictimization and how nurses can help facilitate resilience and provide the appropriate interventions to prevent sexual revictimization.

In addition, all the studies discussed here were retrospective. Prospective longitudinal studies should be conducted in order to better chart and understand resilience and sexual revictimization in young adulthood for females. This type of study would follow CSA survivors from the incident of the CSA to adulthood which would shed light as to what the meaning of resilience is for CSA survivors. This will also allow for differentiating what the specific indicators are for resiliency in childhood, adolescence and adulthood. At the same time the mechanisms as to why sexual revictimization occurs will be determined and so will the fact as to whether resilience is a protective factor against revictimization, and what protective factors are needed to decrease sexual revictimization.

Studies also need to focus on the type of CSA experiences, who the perpetrator was and cultural differences in CSA survivors. These factors will influence the meaning of resiliency and risk factors and protective factors against sexual revictimization.

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Conclusion

In conclusion, prospective studies will be able to answer the question as to whether resilience is a protective factor against sexual revictimization during adolescence and/or adulthood for female CSA survivors. We do know that there is a relationship between indicators of resilience in young adult women survivors of CSA and sexual revictimization, but this association needs to be further researched. Once this has been established, prevention strategies can be implemented to help CSA survivors from becoming further sexually revictimized.

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ATTENTION APPLICANTS!

To apply to the MHNIG Education Award or Consumer Support Funding, please obtain the application form from the MHNIG website at www.mhnig.org in the Members link and Forms section. Also, deadlines for both are extended to **October 15, 2006**!

You can log into the website by: **USER ID: member2006**
PASSWORD: mhnig

Canadian Association for Suicide Prevention
St. Michael's Hospital
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MHNIG Education Award

Purpose: ***The purpose of the Education Fund is to enhance the scholarship and clinical capabilities of MHNIG members.***

Award: There will be 2 (two) yearly awards for financial assistance so those MHNIG members can pursue studies and conferences that are directly related to mental health nursing practice. The MHNIG Executive based on the annual budget will determine the amount of the award.

- **Eligibility Criteria:** To qualify for the award, the applicant will:
- Have a current MHNIG membership and have been a MHNIG member for a minimum of 3 (three) consecutive years immediately prior to the year of application
- Have a minimum of 3 (three) years professional experience in mental health nursing
- Be participating in an educational activity relevant to knowledge and practice in the field of psychiatric and mental health nursing.

Educational activities occurring at some point between November 1st and October 31st will be considered for funding such as:

- Course, seminars, certificate programs, attendance at conferences
- Course work at a recognized college or university where the topic is related to psychiatric and mental health nursing practice
- CNA Psychiatric and Mental Health Nursing Certificate Exam

Application Requirements: Applicants will submit 3 (three) stapled copies of the entire application comprised of the following:

- Completed Education Fund Application Form
- Current resume/curriculum vitae, including educational background, professional nursing experience and professional/volunteer activities
- Essay outlining professional beliefs of the educational endeavour (500 words)
- Copy of the course outline from an academic calendar or copy of the course, seminar, workshop, and conference brochure
- List any funding sources accessed in the past 12 months

Submit the Application to:
Kathy Wong, RN, Program Editor
Mental Health Service,
St. Michael's Hospital,
30 Bond Street,
17th Floor Cardinal Carter Wing,
Toronto, ON M5B 1W8

DEADLINE FOR APPLICATION
Postmarked no later than April 15th and October 15th

Consumer Support Funding

Purpose: ***The purpose of the Consumer Support Funding is to assist consumer groups in their educational endeavours.***

Award: There will be 2 (two) yearly awards for financial assistance. The MHNIG Executive based on the annual budget will determine the amount of the award.

Eligibility Criteria: To qualify to apply for the funding, the consumer group will:

- Formally request the funding outlining their need
- Outline their planned educational activity
- Funding will be limited to once every 5 years for an individual group

Educational activities occurring at some point between November 1st to October 31st will be considered for funding support.

Application Requirements: Applicants will submit a request in writing comprised of the following:

- Completed Application Form
- A letter outlining their educational activity that warrants funding
- Other funding sources sought and obtained

Submit the Application to the Past President:
Tricia Stiles
41 Bedford Road, RR #5
Guelph, ON N1H 6J2

Deadline for Application:
Postmarked no later than April 15th and October 15th.

Review Process:
The Past President of MHNIG will assemble a team of two additional reviewers from the MHNIG membership to assess the applicants based on the criteria and application requirements.

Review Criteria:
Is the relevance of the educational initiative to applicant's group clearly stated? Is the educational activity relevant to consumers?

Administration of Funds:
When approved by the Executive, written confirmation will be provided and cheque will be sent.

Final Report:
A brief final report outlining the educational activity made possible by the funding will be submitted as soon as possible. This report may be published in an upcoming MHNIG newsletter.

Vision & Objectives

MNHIG is an interest group of RNAO and an affiliate of the Canadian Federation of Mental Health Nurses (CFMHN).

1. To provide a forum for communication and the exchange of ideas.
2. a) To promote the health and well-being of people who are at risk of experiencing mental illness and/or emotional distress.
   b) To promote the development of mental health services that are responsive to the needs and wishes of consumers and the community.
3. a) To collaborate with consumers/survivors and family groups.
   b) To collaborate and clarify our roles with mental health professionals.
4. To lobby on behalf of mental health nursing for the recognition of, and positive image of mental health nursing.
5. a) To promote the awareness of the practice of mental health nursing.
   b) To serve as liaison with the RNAO and CNA and certification of mental health nurses.
6. To promote professional growth and best practices in changing mental health care trends.
7. To support participation of mental health nurses in education and research

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SUBMISSIONS TO THE NEWSLETTER ARE WELCOME!

This newsletter can be your voice. Please share your stories, ideas and thoughts. Due date for articles for the next newsletter is January 5, 2007. Submit items to Newsletter Coordinator via e-mail above or mail to:

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